Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

DDD MORTALITY REVIEW

PART 1. PROVIDER REPORT

NAME OF PERSON COMPLETING FORM (PRINT)	
POSITION/TITLE	
DATE COMPLETED	TELEPHONE NUMBER

Complete upon the death of a person who was receiving services from a contracted or licensed provider or was being transported to/from services provided by contracted or licensed providers. **This report must be sent to the DDD Case Resource Manager (CRM) within (21) calendar days of the person's death.** Note: The person completing the form is not attempting to render a professional opinion and is operating based on the facts as they know them immediately following the death.

I. GENERAL INFORMATION

1. DECEASED'S LEGAL NAME (FIRST NAME)	2. MIDDLE NAME	3. LAST NAME

4. ADDRESS

5. AGENCY NAME	6. LOCAL NAME, IF DIFFERENT

7. GENDER	8. ETHNICITY
☐ Male ☐ Female	☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American

9. DATE OF DEATH (MM/DD/YYYY)	10. TIME OF DEATH	11. DATE OF BIRTH (MM/DD/YYYY)
	: ☐ AM ☐ PM ☐ Estimate	

12. AGE LAST BIRTHDAY	13. AGE, IF LESS THAN ONE YEAR, MORE THAN ONE DAY
YEARS ☐ Unknown	MONTHS DAYS ☐ Unknown

14. CITY OR TOWN OF DEATH	15. DATE OF INJURY (MM/DD/YYYY)	16. HOUR OF INJURY
		: ☐ AM ☐ PM ☐ Estimate

17. APPARENT CAUSE OF DEATH INCLUDE SOURCE OF INFORMATION

18. APPARAENTLY DUE TO OR AS A CONSEQUENCE OF

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE APPARENT CAUSE LISTED ABOVE (SUCH AS SIGNIFICANT ILLNESS OR DISEASE)

20. CASE REFERRED TO MEDICAL EXAMINER/CORONER	21. AUTOPSY CONDUCTED:
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

22. PLACE OF DEATH OTHER THAN VEHICULAR INJURY (CHECK ALL THAT APPLY)

☐ Deceased's residence
☐ Relative/guardian's residence
☐ Friend's residence
☐ Adult Family Home
☐ ARC/Boarding Home
☐ Foster Home
☐ Nursing Facility
☐ Residential Habilitation Center
☐ School
☐ Day program
☐ Work place
☐ Hospital
☐ Mental Health Facility/Diversion Bed
☐ DDD Diversion Bed

☐ Public location (specify): _____

☐ Other (specify): _____
☐ Unknown

Was provider aware of client's location at time of death? ☐ Yes ☐ No (explain):

I. GENERAL INFORMATION (CONTINUED)

23. STREET ADDRESS OF RESIDENCE	24. APT NO	25. CITY OR TOWN	26. COUNTY	27. STATE	28. ZIP CODE

29. TYPE OF RESIDENCE WHERE DECEASED LIVED

- ☐ Own home (24 hour on duty staff)
- ☐ Own home (24 hour available staff)
- ☐ Own home
- ☐ Parent's home
- ☐ Adult Family Home
- ☐ ARC/Boarding Home
- ☐ Community ICF/MR
- ☐ DDD Group Home
- ☐ Foster Home
- ☐ Nursing Facility
- ☐ Homeless
- ☐ RHC
- ☐ SOLA
- ☐ State Hospital
- ☐ Other (specify): _____

30. CHECK ALL PEOPLE KNOWN TO BE LIVING WITH THE PERSON AT THE TIME OF DEATH AND WRITE HOW MANY IN EACH CHECKED CATEGORY

- ☐ Biological or adoptive parent: _____
- ☐ Foster parent: _____
- ☐ Step-parent: _____
- ☐ Parent's boyfriend/girlfriend
- ☐ Sibling: _____
- ☐ Other relative: _____
- ☐ Spouse
- ☐ Housemate: _____
- ☐ Children under age 18: _____
- ☐ Agency staff: _____
- ☐ Institution staff: _____
- ☐ None
- ☐ Unknown

II. CIRCUMSTANCES OF DEATH (CHECK ALL CIRCUMSTANCES THAT MAY APPLY, THEN COMPLETE ONLY THOSE SECTIONS INDICATED)

1. CHECK ALL CIRCUMSTANCES THAT APPLY.

- ☐ Fire (complete Section II.A.)
- ☐ Burn (complete Section II.B.)
- ☐ Fall (complete Section II.C.)
- ☐ Firearm (complete Section II.D.)
- ☐ Drowning (complete Section II.E.)
- ☐ Poisoning/drug intoxication (complete Section II.F.)
- ☐ Vehicular injury (complete Section II.G.)
- ☐ Medical conditions (complete Section II.H.)
- ☐ Other circumstances (explain in Section V, Narrative)

2. Was 911 called? ☐ Yes ☐ No

3. IF YES, WHEN

4. BY WHOM

II. A. FIRE

5. CHECK ALL CIRCUMSTANCES THAT MAY APPLY.

- ☐ Cigarette
- ☐ Matches
- ☐ Lighter
- ☐ Combustible liquid
- ☐ Electric blanket
- ☐ Electric wire
- ☐ Explosives
- ☐ Fireplace
- ☐ Fireworks
- ☐ Furnace
- ☐ Cooking appliance
- ☐ Space heater
- ☐ Wood or pellet stove
- ☐ Other (specify): _____
- ☐ Unknown

	YES	NO	UNKNOWN	NOT APPLICABLE
6. Was a smoke alarm present?	☐	☐	☐	☐
7. If yes, did smoke alarm function properly?	☐	☐	☐	☐
8. Was a fire extinguisher present?	☐	☐	☐	☐
9. If yes, did fire extinguisher function properly?	☐	☐	☐	☐
10. Did a fire escape plan exist for structure in which fire occurred?	☐	☐	☐	☐
11. Had the deceased practiced an escape plan?	☐	☐	☐	☐

II. B. BURN

12. SOURCE OF BURN (OTHER THAN FIRE)

- ☐ Hot liquid (specify): _____
- ☐ Space heater
- ☐ Chemical (specify): _____
- ☐ Appliance (specify): _____
- ☐ Other (specify): _____
- ☐ Unknown

II. CIRCUMSTANCES OF DEATH (CONTINUED)

II. C. FALL

13. FALL WAS FROM OR INTO:

☐ Open window, no screen ☐ Natural elevation (e.g., tree, cliff) ☐ Opening in surface (e.g., wall)
☐ Open window, screened ☐ Bed ☐ Same height (e.g., tripping)
☐ Furniture ☐ Stairs, steps, porch
☐ Other (specify): _____
☐ Unknown(explain): _____

14. WAS THE DECEASED AMBULATORY?
☐ Yes ☐ No

15. WAS THE DECEASED USING A MOBILITY AID AT TIME OF THE FALL?
☐ Yes ☐ No ☐ Unknown

IF YES, TYPE OF DEVICE:
☐ Wheelchair ☐ Walker
☐ Cane ☐ Other

II. D. FIREARM

16. TYPE OF FIREARM
☐ Handgun ☐ Rifle ☐ Shotgun ☐ Other: _____ ☐ Unknown

17. APPARENT USE OF FIREARM AT TIME OF INJURY
☐ Cleaning ☐ Loading ☐ Target shooting ☐ Intent to harm
☐ Hunting ☐ Playing ☐ Demonstrating
☐ Other: _____
☐ Unknown

18. WHO OWNED THE FIREARM?
☐ Deceased ☐ Relative ☐ Friend ☐ Provider ☐ Unknown ☐ Other: _____

19. WHERE WAS THE FIREARM STORED?
☐ Gun safe ☐ Drawer ☐ Closet ☐ Unknown ☐ Not applicable
☐ Other: _____

20. WAS THE GUN KEPT LOCKED?
☐ Yes ☐ No ☐ Unknown ☐ Not applicable

21. WAS AMMUNITION STORED WITH FIREARM?
☐ Yes ☐ No ☐ Unknown ☐ Not applicable

II. E. DROWNING

22. PLACE OF DROWNING
☐ Ocean ☐ Lake ☐ Bath tub ☐ Well
☐ Sound ☐ Pond ☐ Hot tub ☐ Irrigation or drainage ditch
☐ River ☐ Creek ☐ Swimming pool
☐ Other (specify): _____
☐ Unknown

23. DECEASED'S ACTIVITY AT TIME OF DROWNING
☐ Bathing in a tub ☐ Swimming ☐ Playing near water (beach, dock)
☐ Boating ☐ Playing in water ☐ On a rubber raft or inner tube while playing in the water
☐ Other (specify): _____
☐ Unknown

	YES	NO	UNKNOWN	NOT APPLICABLE
24. Was the area gated?	☐	☐	☐	☐
If yes, the gate was: ☐ Locked ☐ Unlocked ☐ Unknown				
25. Was lifeguard present?	☐	☐	☐	☐
26. Was a warning sign posted?	☐	☐	☐	☐
27. Was the deceased able to swim?	☐	☐	☐	☐
28. Was the deceased wearing an official flotation device?	☐	☐	☐	☐

II. CIRCUMSTANCES OF DEATH (CONTINUED)

II. F. POISONING/DRUG INTOXICATION

29. TYPE OF POISONING/DRUG INTOXICATION (SPECIFY NAME OF SUBSTANCE INVOLVED ON LINE PROVIDED FOR EACH ITEM CHECKED) AND STATE YOUR SOURCE OF INFORMATION

- ☐ Over-the-counter medication _____
- ☐ Medication prescribed for deceased _____
- ☐ Medication prescribed for another _____
- ☐ Chemical _____
- ☐ Illegal drug _____
- ☐ Alcohol _____
- ☐ Carbon monoxide (CO) _____
- ☐ Other gas inhalation/huffing _____
- ☐ Food product _____
- ☐ Herbal remedy _____
- ☐ Other _____
- ☐ Unknown

30. LOCATION WHERE SUBSTANCE WAS REPORTEDLY STORED

- ☐ In closed, locked area ☐ In closed, unlocked area ☐ In open area ☐ Not applicable
- ☐ Other _____
- ☐ Unknown

	YES	NO	UNKNOWN	NOT APPLICABLE
31. Was substance stored per contract requirement? If no, explain in Section IV.	☐	☐	☐	☐
32. If carbon monoxide poisoning, was a CO detector present?	☐	☐	☐	☐
33. If CO detector was present, was it functioning properly?	☐	☐	☐	☐
34. Was Poison Control Center called at time of poison/drug intoxication?	☐	☐	☐	☐
35. If medication, was it dispensed per MD's order? If no, explain in Section IV.	☐	☐	☐	☐

II. G. VEHICULAR INJURY

36. VEHICLE IN/ON WHICH DECEASED WAS AN OCCUPANT

- ☐ Bicycle ☐ Car ☐ Riding mower ☐ Truck ☐ All terrain vehicle
- ☐ Boat ☐ Motorcycle ☐ School bus ☐ Van
- ☐ Bus ☐ RV ☐ Snowmobile ☐ Wheelchair
- ☐ Other _____
- ☐ Unknown

37. VEHICLE THAT STRUCK PERSON OR PERSON'S VEHICLE

- ☐ Bicycle ☐ Car ☐ Riding mower ☐ Truck ☐ All terrain vehicle
- ☐ Boat ☐ Motorcycle ☐ School bus ☐ Van
- ☐ Bus ☐ RV ☐ Snowmobile ☐ Wheelchair
- ☐ Other _____ ☐ None, deceased was a pedestrian
- ☐ Unknown
- ☐ Not applicable

38. POSITION OF DECEASED

- ☐ Driver ☐ Passenger, back seat ☐ Passenger, position unknown
- ☐ Passenger, front seat ☐ Passenger, middle seat ☐ Pedestrian
- ☐ Other _____
- ☐ Unknown

II. CIRCUMSTANCES OF DEATH (CONTINUED)

II. G. VEHICULAR INJURY (CONTINUED)

39. LOCATION OF ACCIDENT (CHECK ALL THAT APPLY)

☐ City street ☐ Freeway ☐ Shoulder
☐ Driveway ☐ Highway ☐ Rural road
☐ Intersection ☐ Sidewalk ☐ Off-road (e.g., dirt road, snow)
☐ Body of water (specify) _____
☐ Other _____
☐ Unknown

40. POSSIBLE CONTRIBUTING FACTORS OF VEHICLE ACCIDENT (CHECK ALL THAT MAY APPLY)

☐ Adverse road conditions ☐ Mechanical failure ☐ Alcohol and/or drug intoxication (see Section III, questions 3 – 5)
☐ Excess speed ☐ Driver error ☐ Adverse weather conditions
☐ Other _____
☐ Unknown

41. AGE OF DRIVER OF VEHICLE IN WHICH DECEASED WAS RIDING: _____ YEARS ☐ Unknown ☐ Not applicable

42. AGE OF DRIVER OF VEHICLE THAT STRUCK DECEASED OR DECEASED'S VEHICLE: _____ YEARS ☐ Unknown ☐ Not applicable

43. WHAT RESTRAINTS WERE PRESENT IN VEHICLE? FOR THOSE RESTRAINTS PRESENT, CHECK IF THEY WERE USED.

☐ Infant seat	☐ Used	☐ Not used	☐ Unknown
☐ Toddler/booster seat	☐ Used	☐ Not used	☐ Unknown
☐ Customized restraints.....	☐ Used	☐ Not used	☐ Unknown
☐ Seatbelt	☐ Used	☐ Not used	☐ Unknown

☐ Unknown

	YES	NO	UNKNOWN	NOT APPLICABLE
44. Was the deceased wearing a seat belt?	☐	☐	☐	☐
45. Was the deceased sitting in a seat with an airbag?	☐	☐	☐	☐
46. Was the deceased injured by a deploying airbag?	☐	☐	☐	☐
47. Was the deceased wearing a safety helmet at the time of injury?	☐	☐	☐	☐

II. H. DIAGNOSED MEDICAL CONDITIONS

48. CONDITIONS EXISTING PRIOR TO THE PERSON'S DEATH (CHECK ALL THAT APPLY)

☐ Allergies (type): _____
☐ Arthritis
☐ Alzheimer's
☐ Anemia
☐ Cancer (type): _____
☐ Coronary Disease: ☐ Cardiopulmonary ☐ Congestive Heart Failure ☐ Myocardial Infarction ☐ Other
☐ Diabetes: ☐ Insulin Dependent ☐ Non-insulin Dependent
☐ Fracture(s) (type): _____
☐ Gastric disease
☐ Hypertension
☐ Hypotension
☐ Hypothyroidism
☐ Notifiable Condition/Communicable Disease (specify): _____
☐ Renal/kidney disease
☐ Respiratory disease:
☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Pneumonia ☐ Recurrent aspiration
☐ Seizures
☐ Sepsis
☐ Surgical Procedure: _____ Reason: _____
☐ Surgical Procedure: _____ Reason: _____
☐ Surgical Procedure: _____ Reason: _____
☐ Swallowing disorder: ☐ G-tube
☐ Syndrome (specify): _____
☐ Thrombosis
☐ Other: _____

II. CIRCUMSTANCES OF DEATH (CONTINUED)

II. H. CHRONIC MEDICAL CONDITION (CONTINUED)

49. Was deceased treated by a health care provider within 30 days of date of death? ☐ Yes ☐ No ☐ Unknown
    Diagnosis:

50. Was deceased hospitalized for this condition? ☐ Yes ☐ No ☐ Unknown
51. Was deceased in hospice care? ☐ Yes ☐ No ☐ Unknown

III. MEDICATIONS

1. Was deceased on prescribed medications? ☐ Yes ☐ No
2. List all prescription medications by name, dosage, and frequency.

IV. ADDITIONAL INFORMATION ON CIRCUMSTANCES SURROUNDING DEATH

1. If death was due to an injury, was injury intentional? ☐ Yes ☐ No ☐ Unknown
2. Person alleged to have inflicted injury:
   ☐ None ☐ Unknown ☐ Known (check all that may apply and state source of information):

   - ☐ Self-inflicted _____
   - ☐ Biological or adoptive mother _____
   - ☐ Biological or adoptive father _____
   - ☐ Stepmother _____
   - ☐ Stepfather _____
   - ☐ Foster parent _____
   - ☐ Mother's boyfriend/girlfriend _____
   - ☐ Father's girlfriend/boyfriend _____
   - ☐ Sibling _____
   - ☐ Friend _____
   - ☐ Acquaintance _____
   - ☐ Respite care provider _____
   - ☐ Agency staff _____
   - ☐ Institutional staff _____
   - ☐ Housemate _____
   - ☐ Stranger _____
   - ☐ Other (specify) _____

3. Was anyone involved using drugs or alcohol at the time of the incident? ☐ Yes ☐ No ☐ Unknown

4. IF YES, PERSON(S) IMPAIRED (CHECK ALL THAT APPLY)

- ☐ Deceased
- ☐ Agency staff
- ☐ Relative/guardian _____
- ☐ Housemate _____
- ☐ Other _____
- ☐ Other _____

5. IF YES, TYPE OF SUBSTANCE(S) USED (CHECK ALL THAT APPLY)

- ☐ Alcohol
- ☐ Drug (specify) _____
- ☐ Other _____
- ☐ Unknown

EXPLAIN ALL YES ANSWERS IN SECTION IV BELOW.

	YES	NO	UNKNOWN
6. While under your care or in your program, had deceased ever attempted suicide? ...	☐	☐	☐
7. Was death an apparent suicide?	☐	☐	☐

V. NARRATIVE

BRIEFLY DESCRIBE THE CIRCUMSTANCES OF DEATH AND ANY ADDITIONAL INFORMATION NECESSARY. INCLUDE ANY CONCERNS OF FAMILY OR GUARDIAN. SPECIFY POSITION/TITLE OF ALL PERSONS REFERENCED.